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Staff Report

Research on Board of Health Priorities

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Section 1: Overview

Introduction

In the summer of 1999, the Washington State Board of Health established a set of priority issues that guided its work during the 1999-2001 biennium. It chose to focus on:

- health disparities;
- environmental justice;
- children's health and well being;
- communicable disease reporting;
- access to critical health services;
- public health system improvements.

For each priority area, the Board created a work plan. The Board has completed or is about to complete the bulk of the tasks laid out in those plans. In July 1999, after a deliberative public process, the Board adopted new HIV reporting requirements. It also successfully collaborated with the Department of Health to streamline and update the notifiable conditions rule. Board members and staff have participated in the work on the Public Health Improvement Plan (PHIP) and in September the Board adopted a "Menu of Critical Health Services" as a specific contribution to the PHIP. In November, the Board adopted a list of "Critical Preventive Services for Children, Birth to Age 10." At its May meeting, the Board accepted a final report and recommendations on health disparities and workforce diversity. At its June meeting, it adopted a similar report and set of recommendations on environmental justice.

The Board is now preparing to set new priorities that will guide its work through the 2001-03 biennium. To inform the Board's deliberations, which are expected to begin during the July meeting, Board staff have undertaken a series of research projects:

- a review of testimony given at public forums held around the state in 2000.
- a review of documents that provide top-level data on health trends;
- a survey of key informants soliciting input about future Board's priorities;
- a Web-based questionnaire, similar to the key informants interview, that enabled visitors to the Board's Web site to provide input;
- a letter to Laurie Garrett, Pulitzer Prize-winning author, soliciting her input;
- a review of public opinion polls and popular press coverage;
- a preliminary review of current and planned work by other agencies, academic centers, and foundations involved in developing public health policy.

Taken together, these efforts were designed to tap into the knowledge and opinions of a broad base of constituencies involved in public health. They are also an attempt to identify areas where the Board's work could have a significant and unique impact. One goal has been to identify pressing public health needs—as defined by the informed opinions of public health professionals and by data-driven, science-based research—that are not getting the attention they warrant. Another goal has been to identify opportunities to enlist support from policy-makers, opinion leaders, academic and scientific experts, the press, and the general public.

These activities also fulfill a portion of the Board's statutory responsibility under RCW 43.20.050. The code section requires that the Board gather citizen input at public forums around the state every five years and publish a state health report every two years. The state health report must take into account:

- input from public forums
- best available information collected and reviewed by the Department of Health (RCW 43.70.050)
- assistance from local health departments
- recommendations from the directors of state health agencies

The Board convened public forums in 2000, and its staff considered Department of Health information in the literature review. Individuals surveyed included local health officers and environmental health officers and officers of the Washington State Association of Washington Public Health Officers. They also included all agency directors (or their designees) described in RCW 42.30.050 with the exception, to date, of the director of agriculture and the director of labor and industries. This report, then, in addition to informing the Board's choice of priorities, lays some of the groundwork for the next health report.

Detailed descriptions of the methodologies and findings from the literature review and the survey research appear in later sections of this report. This section provides a brief overview of the context in which the Board is operating and describes individual observations by staff members about a limited number of issues that emerged from the combined mass of these interrelated efforts. The Board's past priorities and stated interest in possible future areas of work influenced decisions about which areas to highlight.

It is important that the Board keep in mind that staff reviewed a lot of data and collected a lot of input, some of which was contradictory. Trying to identify patterns among so much information is, of necessity, a subjective process. Nothing in this report constitutes a staff recommendation to the Board. The sole recommendation is that Board members review as much of the material as possible, and ask as many follow-up questions as needed, prior to the July 11 Board meeting.

Overview

Healthy People 2010, the federal strategic plan for public health, identifies the leading causes of death as:

1. Heart disease
2. Cancer
3. Stroke
4. Chronic obstructive pulmonary disease
5. Unintentional injuries
6. Pneumonia/influenza
7. Diabetes
8. Suicide
9. Kidney disease
10. Chronic liver disease and cirrhosis

It has identifies the leading health indicators as:

1. Physical activity
2. Overweight and obesity
3. Tobacco use
4. Substance abuse
5. Responsible sexual behavior
6. Mental health
7. Injury and violence
8. Environmental quality
9. Immunization
10. Access to health care

The central goals of Health People 2010 are to (1) reduce health disparities and (2) increase quality and years of health life.

Statewide statistics about the top causes of death in Washington are largely consistent with the national data. The state's *2000 Public Health Improvement Plan*, looks more at indicators of health and less at indicators of disease. As "general health indicators," it uses (1) years of healthy life, (2) perceived mental health, and (3) readiness to learn.

The *2000 Public Health Improvement Plan*, adapting information from the March 1997 *Journal of Public Health Management and Practice*, estimates that 10 percent of our health can be attributed to access to health care, 20 percent can be attributed to environmental factors, 20 percent can be attributed to genetics, and 50 percent can be attributed to health behaviors.

Overall, our health is improving. People are living longer and being more productive and active later in life. Nationally, most health indicators are headed in a positive direction. The incidence of disease and the prevalence of risky behaviors is, on average, declining. Washington follows this pattern, and by many measures Washingtonians lead healthier lives than their counterparts in the rest of the nation.

There are, however, numerous exceptions—areas where health is declining, where trends are negative, and where Washingtonians are less healthy than the rest of the country. For example:

- Cancer incidence rates and death rates are declining nationally, but the incidence of breast cancer climbed 1.2 percent annually between 1992 and 1998.
- The number of Washington residents who report that they have no leisure-time physical activity is below the national average, yet 65 percent of the men in this state are overweight.
- Washington residents smoke less than the rest of the country, but the number of school children who use tobacco is higher than it is nationwide and the incidence of lung cancer deaths is higher.
- Teen pregnancy rates and utilization of prenatal care are improving in Washington, but the number of preterm and low-birthweight births is rising.

Washington state enjoys a diverse, multifaceted network of organizations developing health policy and providing health services.

Participants in the public health network include the Board, the Department of Health, 34 local health jurisdictions, and the University of Washington School of Public Health and Community Medicine. This network is highly regarded nationally for its level of innovation, collaboration, and coordinated planning. Other highly involved organizations include the Washington Association of Public Health Officers, associations representing health professionals, the hospital and health plan associations, and health foundations.

Several state agencies have health-related responsibilities, including the departments of Health, Ecology, Agriculture, and Labor and Industries, the Health Care Authority, the Office of the Insurance Commissioner, and the Office of the Superintendent of Public Instruction. In January, the governor established by executive order a sub-cabinet on health. The Legislature and the Governor's Office are also involved in health issues. The governor's policy office currently has a $1.3 federal grant to study health access issues.

Several existing public and private programs effectively address many of the state's health needs. For example, the Department of Health is using tobacco settlement money to fund an aggressive anti-smoking campaign aimed primarily at teens, and the Watch Your Mouth campaign, a privately funded effort, is apparently effective at promoting oral health care for children.

Arguably the most critical policy dilemma that, in many people's minds, is not being addressed adequately is access to quality, affordable care. This encompasses a broad set of inter-related issues, including unreimbursed care, provider shortages, low reimbursement rates, emergency room utilization, the number of people uninsured or uninsurable, escalating government costs, prescription drug costs, and health disparities. There is widespread anxiety about these issues among health providers, policy makers, and the general public.

The state fiscal climate, especially for health, is bleak. Voter initiatives have reduced revenue while increasing the share of state funds committed to schools, teacher salaries, and transportation. The rising costs of providing state health insurance (e.g., Medicaid) and various health care services are straining the budget even further. For the next few years, cuts in health services, government insurance, and employee coverage seem likely.

Health Disparities

Healthy People 2010 identified two major goals for the nation's health in the next decade, and one is to reduce health disparities (the other is to increase quality and years of healthy life). The health disparities issue is also a theme that touches on many of the determinants listed in *Healthy People 2010*. For specifics about the severity of disparities in Washington, please consult the May report for the Board's Subcommittee on Health Disparities.

The key informants interviewed and the people who responded to the on-line survey overwhelmingly supported the Board's past work on health disparities and many suggested that it continue. When asked to rate items on the Board's short list of possible priority projects, continuing to work on health disparities scored highest across all groups. Support for health disparities work was widespread and consistent. Major themes included: continue workforce diversity efforts; examine racism in health care settings; and examine affordability of care, provider access, and insurance availability for the poor and for communities of color.

The May 9 Board report on health disparities details some of the health disparities work being conducted in this state. There have also been recent developments not reflected in that document:

- The draft vision statement for a DOH workgroup on the health professions and workforce development calls for creating "a diverse workforce reflecting the populations where health risks are most prevalent."
- The Public Health Improvement Plan list of "next steps" includes: "Increase the proportion of under-represented racial and ethnic groups in the public health workforce so it reflects the community it serves."
- A group of public health professionals wanting to play a more activist role in eliminating disparities has formed in the Seattle region under the name Health Justice Network.

Children's Health and Children's Mental Health

There was strong support in the survey research for the Board to continue working on children's issues. In particular, there was support for seeking a public/private partnership that would secure funding for continued universal distribution of vaccines. This received the highest score among people interviewed by Board staff and scored well among academics and people who completed the on-line survey.

All groups of respondents were supportive of continuing to work on the list of children's preventive services.

Some people identified children as a target population under the broader heading of "vulnerable populations." Currently, one-seventh of all children live in deep poverty. One-third of all children do not get their basic needs met due to poverty.

Among academic interviewees, there was even stronger support for working on children's oral health and mental health issues. Support for these projects, however, dropped off among the subjects interviewed by Board staff.

According to the U.S. Agency for Health-Care Research and Quality, 57.5 percent of all children had no dental visits during 1996. The figure for African Americans and Hispanics was over 70 percent and the figures for children without insurance was over 80 percent. One reason given for not supporting more Board involvement in children's oral health issues was the work already being done by the Watch Your Mouth campaign. There already is an oral health component to the Board's work on the list of children's

preventive services. Also, the Legislature this session passed a bill that allows dental hygienists to provide dental care to at-risk children in underserved schools.

The supporting material for the Board list of children's preventive services notes that one in five children between the ages of six and 11 will develop mental health problems. Answers to the interviews suggest that one reason for the drop-off in support for children's mental health issues among some key informants may be due to political pragmatism about the reality of expanding benefits in today's fiscal climate.

Environmental Health

Environmental issues are thought to account for about 20 percent of our health.

Public opinion polls consistently show that the public believes there is a role for government in protecting them from environmental hazards. This includes both traditional environmental health functions such as food safety, protection of drinking water, and regulation of sewage, as well as broader environmental quality issues like air pollution, nuclear waste, and pesticide exposure. The Board's 1997 survey was fairly typical: When asked to pick the most important health area for state government to work on, "environmental hazards" was third (15.6 percent), just behind "access to health care" and "alcohol/drugs."

The Pew Charitable Trusts commissioned a May 1999 public opinion study that found that Americans want more money put into what they believe is an inadequate public health system, that there is widespread agreement that environmental factors are a major cause of disease, that the public is confused and needs more information about how environmental health problems are monitored, and that there is strong support for a system that tracks chronic diseases that may be environmentally related.

The Washington Department of Ecology report *Washington's Environmental Health 2000* shows that most types up air pollution are declining, water quality is generally improving (though a slightly higher percentage of municipal water supplies are showing high levels of nitrate-nitrogen), and the amount of hazardous waste generated is declining. Persistent bioaccumulative toxins are an emerging area of concern.

When asked to identify priorities for the Board, several key informants and Web survey respondents urged a continued focus on traditional environmental health issues. Many people raised a host of environmental concerns, such as air pollution and nuclear cleanup, but no single dominant issue emerged. There was some support for making PBTs a Board priority and significant support for continuing to monitor the issue. There was little support for working on global warming or even continuing to monitor it, except among respondents to the Web survey. The responses appear to be consistent with recent public opinion polls that show that the people overwhelming believes that global warming is a real problem but they don't attach much urgency to the issue.

Public Health Improvement

Many people interviewed, especially academics, raised the issue of public health infrastructure. The specific issue mentioned most often was the need for continued state support for the Public Health Improvement Partnership, a collaboration working to promote the health of the people of Washington. The Board is a member of the partnership, along with local health jurisdictions, the Department of Health, and the University of Washington School of Public Health and Community Medicine. These collaborative efforts resulted in publication of the 2000 Public Health Improvement Plan (PHIP). The 2000 version is Washington's fourth PHIP.

The partnership is "on task" to complete most of its 1999–2001 work plan by the end of June 2001. The PHIP contains a series of "next steps" that will shape the work plan for 2001–03. As a partner in the PHIP process, the Board will contribute to this work plan. Last year, for example, it created a menu of critical health services as its contribution to fulfilling the 1999–2001 PHIP work plan. Executive Director Don Sloma is representing the Board in the PHIP planning process and will be able to represent the Board priorities to the partnership.

The next steps include collecting data for a preliminary "Washington Report Card for Health," adopting and implementing the Proposed Standards for Public Health, developing common data standards for reporting public health statistics, enumerating the public health workforce, and disseminating the menu of critical health services. A summary of next steps excerpted from the PHIP appears on the following page.

Of particular note in this work is the effort to standardize the reporting of public health data. This has been a monitor item for the Board. A significant number of interviewees and survey respondents suggested promoting it to priority status. Others pointed to the work already being done by DOH and the PHIP partnership as a possible reason why Board doesn't need to be more involved in this issue.

Health Access

It is estimated that access to care accounts for about 10 percent of what determines our health status (2000 Public Health Improvement Plan).

In 1997, the Board commissioned a statewide opinion survey. When asked to name the most important health area on which state government should work, the greatest number (22 percent of 1,568 respondents) said access to health care. When asked about the seriousness of various issues, the greatest number (79 percent) said state government should give access to health care a high or very high priority (1998 Washington State Health Report). Many local health assessments completed in 1997 and 1998 listed access to care as an area of concern.

Access issues have deteriorated since 1997. The percentage of uninsured in Washington (10 to 15 percent) is below or near the national average, but uninsured rate appears to be rising and there are population subgroups with much lower rates of coverage. There are

severe workforce shortages for key professions (nurses, pharmacists, etc.). Physicians, particularly primary care physicians, are reportedly leaving the state or retiring, in part because of low reimbursement rates. Large physician organizations have restructured or closed because of financial difficulties. Many counties are without dental care for Medicaid patients and health plans have dropped Medicaid and Medicare coverage, as well as individual insurance products. Emergency room overflows are increasing. Even people with coverage are having difficulty finding care. A recent report by the Center for Studying Health Systems Change questions the viability of HMOs in the Seattle market. And the cost of providing care to state employees and people on state insurance plans is a major contributor to the state's budget woes. It's not surprising that 600 people were concerned enough to attend a forum on health care with the state's two senators in Olympia last month.

Respondents to the current round of Board surveys agreed that access was a critically important issue and many of them wanted the Board to play a role. When asked to say what priorities they thought the Board should tackle, key informants named access and related issues far more often than anything else. Access-related items on the Board's short list received strong support; support was also strong for elevating health-care financing from monitor status to priority status.

Many of the key informants, however, thought that access issues, while important, should not be a Board responsibility. Either too many people were already working on it, or the issues was too complex and politically charged for the Board to tackle, given its staffing levels and perceived role in state government. At the same time, many informants argued that the Board is uniquely positioned—because it is somewhat insulated from politics and day-to-day program operations—to take a look at the big picture.

Many agency heads encouraged the Board to get involved in access issues, as did some people in the Legislature. Others warned the Board away. The most common perception of how the Board could contribute was by helping the public understand the tradeoffs and challenging the expectation that the health care system can deliver everything to everyone. There is a clear tie-in here to the Board's traditional role of convening public forums. There are also connections to the Board's work this past year on the menu of critical health services, children's preventive services, and health disparities.

Two major access-related developments have occurred at the state government level this year. The first was the creation of the governor's sub-cabinet on health, headed by the administrator of the Health Care Authority. A major focus of the cabinet's early work has been state purchasing decisions for employee health-care and government insurance. Board Executive Director Don Sloma represents the Board on the sub-cabinet.

The second development is a $1.3 million state planning grant from the Health Resources and Services Administration to the Governor's Executive Policy Office in the Office of Financial Management. HRSA has award grants to 20 states that will allow them to profile the uninsured population and develop public/private strategies to provide universal access to adequate, affordable coverage. The Washington grant will be used to determine who lacks insurance and why, examine the current coverage system and find

ways to improve affordability and close coverage gaps, consider community-based innovations, and propose a plan of prioritized steps for achieving universal coverage. The scope of work for a request for proposal to contract out the bulk this work also called for inventorying current efforts to simplify benefits and assessing support for further benefits simplification efforts. There was also a public input component to the scope of work. The contract was awarded to the Health Policy Analysis Program at the University of Washington for $852,829. The grant period is March 1, 2001 through February 28, 2002. Board Executive Director Don Sloma represents the Board on an advisory committee for the grant.

Obesity and Overweight

About 50 percent of our health is determined by our behaviors. The top behaviors that are damaging to our health are tobacco consumption, alcohol and drug abuse, and the inter-related behaviors of physical activity, diet, and nutrition.

When asked to rate the seriousness of various health issues in the Board's 1997 survey, respondents listed, in order, "misuse of alcohol and other drugs," "lack of exercise and poor eating habits," and "tobacco use and secondhand smoke" (tied with "sexually transmitted diseases").

Healthy People 2010, the federal government's strategic plan, lists "physical activity" and "overweight and obesity" as its top two health indicators, followed by "tobacco use" and "substance abuse." Local health assessments have also identified obesity as an issue.

The media have given significant coverage in the last few months to the rise in obesity and, as a result, the increasing incidence of diabetes. They have also covered in some depth the controversy around the sale of candy and soft drinks in school cafeterias.

Most health trends, nationally and in Washington, are moving in the right direction. One of the few exceptions is obesity. Americans are getting fatter. According to the most recent National Health and Nutrition Examination Survey, the number of overweight children and adolescents has nearly doubled in 20 years.

According to the 2000 Behavioral Risk Factor Survey (BRFS), which reports statewide prevalence of risk factors in Washington, 73 percent of the total population does not engage in regular or sustained physical activity during one month. More than 83 percent do not engage in regular or vigorous physical activity during one month. About 55 percent of the total state population is overweight or obese.

On average, higher body weight is associated with higher death rates. Diabetes, which is linked to obesity, has consistently been the sixth or seventh leading cause of death in this state during the 1990s. During that time, the percentage of all deaths resulting from it has risen slowly.

Tobacco use and substance abuse received a few mentions in the key informant interviews and the on-line survey responses, but obesity was one of the items mentioned

most often. (Some people said that they would not include tobacco cessation on the Board's list of priorities because of the excellent work already being done by DOH.)

One of the questions that came up repeatedly was: What is government's role? People have long accepted regulation, even criminalization, of drugs and alcohol. In recent years, they have become more accepting of government interventions aimed at smoking—and in particular tobacco use by minors and exposure to secondhand smoke. But what government role is appropriate, from the public perspective, when it comes to reducing high risk behaviors around diet and exercise—education, social marketing, regulation of advertising, regulation of sales in schools, etc.? One suggestion in key informant interviews was to begin this discussion. Another was to assemble a set of intervention options and explore their relative merits and the likelihood of public acceptance.

It's interesting to note that while respondents in the 1997 survey ranked the seriousness of poor diet and lack of exercise high, relatively few ranked it as the most important area that state government should work on (10th; 3.5 percent).

Public Engagement

Several times during this research the notion of public input and public forums came up. It was mentioned as a Board responsibility when people were asked to describe the role of the Board. It was mentioned in the context of several issues when people were asked about specific projects the Board might undertake. In particular, it came up frequently in the context of access to health. People often said it was a strength that uniquely positioned the Board to deal with delicate issues.

Laurie Garrett, Pulitzer Prize-winning public health journalist and author of *Betrayal of Trust*, spoke to this issue directly, and critically, when staff sought her input about the idea of responding quickly to emerging issues:

> *"[I]t would be important for the people of Washington state to feel that their opinions were being heard. Does this sound threatening to the process? Sure. Groan. That's democracy for you. But you must make a choice: generate another bureaucratic document that may or may not end up being relevant to your agencies' processes, or bring the populace into the process in a manner that leads to longstanding commitments, builds bridges and ultimately increases support for public health across the board. You will undoubtedly discover in the process a long list of unmet needs, roots of health alienation in minority communities and rural areas, a strong unchallenged thread of anti-science sentiments in your citizenry and severe class-based differences in both assessments of what constitutes 'health' and access to it."*

Garrett's point about engagement connects to something else that emerged from this research. The survey and interviews made it clear that the work of the Board is poorly understood. Most respondents are not familiar with the Board and some people in the Legislature—members and staff—questioned its role. This suggests that the Board has more work to do in clarifying and communicating its role, and that there may be a piece of work in 2001-03 that has to do with assessing organizational capacity and effectiveness.

This confusion and lack of understanding about the Board, however, is consistent with the findings of other research about the public's awareness of and support for public health in general. Public opinion surveys consistently show that the public supports public health in a general sense but doesn't understand many aspects of what we so. This was confirmed by strategic communications planning done by the Centers for Disease Control and Prevention and by Public Health—Seattle and King County. The same lack of familiarity was found in focus groups conducted in Washington during strategic communications planning as part of the PHIP.

Again, from Laurie Garrett:

> *"Few Americans appreciate what, exactly, departments of public health do on their behalf. They are not engaged. Public health is lumped together with all other government functions, and therefore is victim to the same antigovernmentalism and alienation that average Americans feel toward the motor vehicle department and the IRS. Before setting priorities, do you have an active means for assessing what your citizenry thinks about health? When I look at your list above it makes good sense from a standard public health perspective: any Ph.D. candidate in public health who made a project of your state would probably come up with roughly the same list. But is it the list your citizenry would prioritize? Probably not. Surveys of American public opinion show very different concerns. Does that mean you should abandon the above, and switch to devoting the lion's share of your resources to pesticide screening of drinking water, analysis of gm foods and mad cow disease? No, I don't think so. But public health departments have to find ways to engage the citizenry, bringing its grassroots leaders into the process, or continue to suffer the slings and arrows of antigovernmentalism and social alienation."*

State Health Report

As mentioned above, the Board is required by statute to submit a report every two years. It last submitted a report, its fifth, in 1998. The governor and key legislative leaders excused the Board from submitting a report in 2000. The next one is due in January 2002.

In the interviews and survey, there was some support (most noticeably among academics) for some central document identifying the key public health issues facing the state. Not everyone who supported this general notion, however, believed the Board's report is the right answer. Some said it would be redundant; other said the Board lacked the resources to tackle something of this scope well. There was mixed support for the report at the Legislature. Senior managers in state government consistently argued that preparing the report was a waste of resources. Overall, the dominant response from people interviewed or surveyed was: Don't do it.

One of the questions before the Board, then, is what to do about the report—try to seek a Legislative change eliminating the report or assigning it to another entity, continue to do the report as before, or try through legislation or consensus to redefine the report in a way that would make the process more manageable and the product more useful.

Section 2: Survey of Surveys

Introduction

State Board of Health staff reviewed more than 40 print and electronic documents as part of its efforts to assist the Board in setting priorities for the 2001-03 biennium. The goal was to provide Board members with a broad overview of current top-level data about health problems, health risks, health status, and public opinion concerning health matters. This project, which is fundamentally a literature review, was identified in earlier Board documents as the "survey of surveys." Staff continues to use that appellation.

Methodology

The volume of studies and policy recommendations being generated in the public health field is staggering. Board staff began the project by identifying a list of primary documents commonly consulted by health policy experts. To expand the list, staff members compared notes among themselves, reviewed materials sent to the Board and accumulated in the course of the Board's work, conducted Internet searches, and interviewed key members of the Department of Health (DOH) about department's databases and reports. DOH also provided access to an archive of local public health assessments. The result was a list of more then 40 source documents—the surveys to be surveyed (see Appendix A).

State of Washington information came primarily from Department of Health (DOH) reports, although the review also encompassed documents from other agencies. Examples of key state documents include the Public Health Improvement Plan (the PHIP is a collaborative effort between state and local health public heath agencies), DOH's *Health of Washington State*, and the Department of Ecology's *Washington's Environmental Health 2000*.

Local documents on the source list consist primarily of community health assessments conducted by local health jurisdictions. Board staff relied on these assessments to evaluate health status and health priorities in local areas. Assessments were required during the 1995-97 biennium (many had a 1998 publication date) but are now discretionary. More recently produced assessments reviewed for this project included those prepared by Public Health—Seattle & King County, Snohomish County Health Department, Yakima County Health Department and Benton-Franklin Health District.

Federal documents include policy and statistical reports from a variety of agencies—primarily the Centers for Disease Control and Prevention (CDC) and other divisions of the Department of Health and Human Services—as well as parts of state-by-state reports specific to Washington. Perhaps the most critical federal document is the U.S. strategic plan for public health, *Healthy People 2010*.

In addition to government materials, the source documents include reports, surveys, and policy briefs from foundations, academic institutions, public opinion research companies, and advocacy organizations—for example, the University of Washington Kids Count Project's *The State of Washington's Children* and PEW Charitable Trust's Public *Opinion Research on Public Health, Environmental Health and the Country's Public Health Capacity to Adequately Address Environmental Health Problems*.

Many documents address a specific health issue, such as tobacco and alcohol use, cancer, or asthma. Most, however, provide broad health assessments or establish overarching policy agendas.

Generally, both national and state health assessments present information from one of two perspectives. Some approach health status by disease category while others looked at health status by health indicator. Health indicators focus on a small number of key health and social issues—known risk factors that lead to an illness or death (indicators can also be indicators of health, rather than indicators of disease). Many of the reports were written within the context of trying to achieve the national objectives set forth in *Healthy People 2010*. The two central goals of *Healthy People 2010* are: (1) increase quality and years of healthy life; and (2) eliminate health disparities.

The nature and format of local health assessments vary because local communities determine the content and approach. In some cases, the assessments look at health issues in terms of the causes of morbidity/mortality. In other cases they examined health issues by health indicators.

Two members of the Board's staff reviewed each document to identify trends, patterns, and emerging issues. The remainder of this section reviews the findings. The findings are first presented by disease (causes of illness and death) and then, in greater depth, by health indicator. Finally, there is a discussion of some issues that cut across findings about both disease and health indicators.

Board staff members have contracted with the Northwest Center for Public Health Practice to review this survey of surveys. NWCPHP reviewers found this portion of the report to be very complete.

Findings

The average life expectancy in the United States is almost 77 years. However there exist major disparities by gender, race and ethnicity, income and education. Life expectancy for men is six years less than for women. Racial and ethnic groups have disparities in their heath status for many conditions. Populations that suffer the worst health status are also those that have the highest poverty rates and the least education. Nationally, most health indicators are moving in the preferred direction, and that is also true for Washington state. Washingtonians tend to be healthier, on average, than U.S. residents as a whole.

Causes of Death

Healthy People 2010 lists the 10 leading causes of death in the United States:

11. Heart disease
12. Cancer
13. Stroke
14. Chronic obstructive pulmonary disease
15. Unintentional injuries
16. Pneumonia/influenza
17. Diabetes
18. Suicide
19. Kidney disease
20. Chronic liver disease and cirrhosis

Heart disease and cancer account for 55 percent of all deaths nationally. The number one killer is heart disease, accounting for more than 31 percent of all deaths, followed by cancer accounting for 24 percent of all deaths. Nationally, cancer incidence rates and death rates (National Cancer Institute, June 5, 2001) are declining overall, but there are increases in some cancers, including breast cancer, melanoma, and some lymphomas. In Washington also, heart disease (26.2 percent) and cancer (24.3 percent) are the top two causes of death. Washington has had about 11,000 cancer deaths annually according to 1999 vital statistics.

The causes of death have been pretty consistent over the year. The major significant change is that HIV has dropped from its ranking of ninth in the early 1990s to 22nd in 1999, largely because of protease inhibitors and multi-drug therapies. Revisions to the International Classification of Disease (from ICD-9 to ICD-10) primarily account for the rise in Alzheimer's Disease from 10th or 11th a decade ago to the sixth spot in 1999.

Nationally and in this state the health status of racial and ethnic minorities tend to be worse than for the total population. African Americans are much more likely to die from health disease, cancer and stroke compared to all races. Other disparities exist for racial and ethnic minorities.

Health Indicators

Healthy People 2010 also lists 10 leading health indicators. The indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. The report emphasizes that underlying each of these indicators is the significant influence of income and education. *Communities Count 2000,* by the Public Health—Seattle & King County, confirms that health indicators that are indicative of poor physical and mental health differ by income and by race.

Leading Health Indicators

11. Physical activity
12. Overweight and obesity
13. Tobacco use
14. Substance abuse
15. Responsible sexual behavior
16. Mental health
17. Injury and violence
18. Environmental quality
19. Immunization
20. Access to health care

Physical Activity: Physical inactivity increases the risk of heart disease and stroke, and its absence worsens blood cholesterol and blood pressure levels. Low levels of activity contribute to other leading causes of death and disability, including osteoporosis, colon cancer, and non-insulin dependent diabetes (*1996 Health of Washington State*). Physical activity throughout life is known to be important for maintaining a healthy body, enhancing psychological well-being and quality of life, and preventing premature death.

Washington data show that in 1997, 64 percent of all adolescents engaged in the recommended amount of physical activity and only 15 percent of all adults engaged in the recommended amount. In addition, 40 percent of adults did not engage in any leisure time physical activity.

The 2000 Behavioral Risk Factor Survey (BRFS) reports statewide prevalence of risk factors in Washington. According to BRFS, 73 percent of the total population does not engage in regular or sustained physical activity during one month. More than 83 percent do not engage in regular or vigorous physical activity during one month.

Overweight and Obesity: Nationally, overweight and obesity are major contributors to many preventable causes of death. On average, higher body weight is associated with higher death rates. The number of overweight children, adolescents and adults has risen over the past four decades. Nationally, total costs attributed to obesity alone amounted to an estimated $99 billion in 1995. The rates of overweight and obesity vary. Adolescents from poor households are almost twice as likely to be overweight or obese. Overweight is especially prevalent among women with lower incomes and less education. The 2000 BRFS reports that about 55 percent of the total population is overweight or obese. Males are almost 20 percent more overweight or obese than females.

Each local health assessment reviewed found that increasing numbers of people are overweight in their communities and large proportions of people do not have adequate physical activity. African Americans and Native Americans are more overweight than Caucasians. In King County, Hispanics were found to be less active but there were no differences in weight by race. In Snohomish County more people are overweight and obesity is increasing steadily. This is especially true for people ages 45 to 64.

Tobacco Use: Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year than AIDS, alcohol use, cocaine use, heroin use, homicide, suicide, motor vehicle crashes, and fires—combined. In the United States, more than 430,000 deaths per year are attributed to tobacco use at an estimated cost of $50 billion per year. In 1997, 36 percent of all adolescents and 24 percent of all adults were smokers in 1997. The 2000 BRFS reports that more than 20 percent of Washington's total population currently smoke. The Department of Health's *Washington State Vital Statistics* report states that half of all pregnant women smoke during pregnancy. In King County, tobacco use has increased, especially for people less than 18 years of age.

Substance Abuse: Alcohol and illicit drug use are associated with many of the country's most serious problems, including violence, injury, and HIV infection. The Department of Social and Health Services' Division on Alcohol and Drug Abuse (DASA) states that use of alcohol and drugs can result in premature mortality, increased disease and disability, poor school performance among youth, crime and delinquency, family distress, motor vehicle crashes, and substantially higher health care and corrections costs.

According to national consensus report entitled *Indicators for Chronic Disease Surveillance* by the Council of State and Territorial Epidemiologists (CSTE), the Association of State and Territorial Chronic Disease Program Directors (ASTCDPD), and the Centers for Disease Control and Prevention (CDC), more than 14 percent of Washington's adult population engages in binge drinking. Also, 5.2 percent of males and 3.7 percent of females engage in heavy drinking. DASA shows that Washington's students in grades 8, 10, and 12 are more likely to have used alcohol, marijuana, and cocaine than students in the same grade levels nationally. The report also shows that Native Americans have the highest lifetime use of alcohol compared to the total population and to any other single racial or ethnic group.

Responsible Sexual Behavior: Unprotected sexual behaviors can lead to a number of physical and mental health effects, including unintended pregnancy, HIV/AIDS, and other sexually transmitted diseases. These in turn can lead to many long-term problems such as infertility, ectopic pregnancy, cancer, death, and increased health care costs (1996 Health of Washington State). Unprotected sex can lead to unintended pregnancies, and sexually transmitted diseases (STDs), including infection with HIV. Responsible sexual behavior can prevent these.

Nationally, more than 12 million people are affected by sexually transmitted diseases every year. Five percent of the state population is infected with HIV. In some subgroups it is much higher—for example, a greater number of young, gay African Americans are infected. In a 1998 Kaiser nationwide pubic opinion poll, when people were asked to rate the importance of AIDS and HIV as a health issue, 52 percent of respondents rated it as one of the most important health issues facing this country

Mental Health: Nationally about 20 percent of the nation's population is affected by mental illness in a given year. Of all mental illnesses, depression is the most common disorder. Major depression is the leading cause of disability and is the cause of more than two-thirds of all suicides each year.

Injury and Violence: Nationally more than 400 people die each day from injuries primarily due to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires, and drowning. Most people sustain a significant injury sometime during their lives due to the risk of injury. The death rate from alcohol-related motor vehicle crashes has dropped substantially over the last 10 years in Washington and in the nation as a whole. Since 1996 the number of deaths per 100,000 has decreased from almost 10 percent per 100,000 to about 4.5 percent per 100,000. The Washington rate for motor vehicle-related deaths are lower than the national average: 4.6 deaths per 100,000 in Washington verses 5.8 deaths per 100,000 in the United States. Lower motor vehicle-related fatality rates are associated with increased use of safety restraints, enforcement of minimum drinking age zero tolerance laws, and statutes setting lower blood alcohol concentration standards while driving intoxicated.

Washington has more suicides (10.6 deaths per 100,000) compared to the national average. Washington has far less homicides than the national average, however, there is a large disparity by racial and ethnic groups—African Americans have four times more homicides than all races together. For the last decade Washington has maintained a lower rate of deaths due to residential fires, but a higher rate of deaths due to drowning when compared to the nation.

Environmental Quality: About 25 percent of preventable illnesses internationally can be attributed to poor environmental quality. Environmental risks come from numerous sources including contaminated outdoor and indoor air; contaminated water supplies; contaminated foods; the physical environment; diseases transmitted to people by animals and insects (e.g., rabies, hantavirus, or Lyme disease), radiation, and hazardous substances (pesticides), according to the 1996 Health of Washington State. The Department of Ecology's Washington's Environmental Health 2000 states that most types of pollution today stem from car exhaust, polluted water carried to storm drains, woodstoves, septic systems, animal waste and fertilize use.

Two indicators of air quality are ozone (outdoor) and environmental tobacco smoke (indoor). Objectives for *Health People 2010* are: (1) to reduce the proportion of people exposed to air that does not meet U.S. Environmental Protection Agency health based standards for ozone; and (2) to reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

The ozone level in Washington spiked in 1998, while other types of air pollution has decreased over the last 15 years. In 1995, thirteen areas of the state were not meeting federal health-based standards. Now eleven of those areas measure air quality clean enough to meet federal standards. The number of people exposed to unhealthy air in

Washington has dropped from 2 million in 1990 to about 112,000 in 1998. In the U.S., air pollution is estimated to be associated with 50,000 premature deaths.

In this state, fresh water monitoring stations are showing an improved condition or no change over the last five years. However, to prevent bacteria in rivers and streams, septic systems need to be inspected and pumped regularly and manure needs to be properly stored and managed. Regarding ground water, currently 7 percent of the tested public water supply wells show high nitrate-nitrogen levels compared to 6 percent in 1997. These sites occur in highly populated and farming areas in the state. The amount of hazardous waste generated each year has been decreasing since 1992 due to efforts by industry to reduce the amount of hazardous chemicals used in business practices.

A 1999 public opinion research report by the PEW Charitable Trusts found that there is widespread agreement that environmental factors are a major cause of disease. The general public is confused about whether and how environmental health problems are monitored and see the need for more information. The report also found that there is strong support for a proposal to create a national system that would track, monitor, and respond to chronic diseases that are caused by environmental

Immunization: Immunization can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities. Immunization rates in Washington total over 95 percent for school-age children. The challenge is to have more children immunized appropriately by age 2. The percent of 2-year-olds fully immunized totaled 80 percent in 1997 and 81 percent in 1998.

Access to Health Care: Access to health care is a major indicator of health both nationally and in the state. Factors that limit access include not having health insurance, lack of an ongoing place of care ("medical home"), as well as financial, structural, and personal barriers. With health care costs increasing, availability of providers shrinking, and health insurance becoming harder to obtain, access is only growing worse. The 2000 BRFS found that slightly more than 10 percent of the state's population has no insurance. This is below the national average of 14.5 percent, but the rate of the uninsured is higher for various subgroups, including people who are in poor health, people living near or below the poverty level, Hispanics, Native Americans, non-citizens, and people between the ages of 19 and 30. Many more people in the state are underinsured**.**

Multiple studies, reports, and articles show that the state's health system along with the national health system is in need for fundamental change. Access to care and quality of care need to be protected and improved. The Institute of Medicine report Crossing the Quality Chasm, A New Health System for the 21st Century, states that as medical science and technology have advanced at a rapid pace, the health care delivery system has floundered in its ability to provide consistent, high-quality care to all Americans.

Common Threads

Several threads run through the disease and health indicator data. The information reviewed indicates that to reduce morbidity and death, the most effective use of resources is to focus on one or more key health indicators, rather than a particular disease. The literature also shows that income and education, along with race and ethnicity, affects a person's health, therefore it cannot be ignored when working with health indicators.

One of the two major goals of *Healthy People 2010* is to eliminate health disparities. Throughout the literature review, disparities in health status are identified. For example, non-Hispanic African American children are more likely to have asthma than other children. They are also more likely to have elevated concentrations of lead in their bloodstream. Native Americans have higher death rates and lower life expectancy that all other racial groups except African Americans. These high death rates are attributable to car crashes, stroke, liver disease, diabetes, suicide and homicides, however overall death rates have decreased recently (*1997 American Indian Health Care Delivery Plan*). Poor health is directly related to socioeconomic characteristics of tribal communities and the common predicament of low-income levels. Health disparities do not exist only by race and ethnicity—poverty is a major risk factor for worse health status.

Another common thread was children's issues. *The State of Washington's Children* shows that there are many improvements in the health status of children: infant mortality has decreased from 9.2 per 1,000 births to 5.7 per 1,000 births over the last ten years. More children are learning and engaging in healthy behaviors. Youth suicide has not increased. Many acute infectious diseases have been eliminated or reduced to almost zero. There has also been a recent decline in teen pregnancy.

The report emphasizes, however, that many challenges remain. For example, income disparities need to be reduced to improve economic conditions for children. Currently, one-seventh of all children live in deep poverty. One-third of all children do not get their basic needs met due to poverty. Children need help to learn and practice healthy behaviors. The epidemic of violence needs to be curbed to assure that children are safe and secure.

According to DOH's Maternal Child Health Five-Year Needs Assessment, the state needs to decrease family violence, unintended pregnancy and teen pregnancy, and tobacco use. Increases are needed in nutrition, oral health, and mental health status. In at least one local health jurisdiction, Benton-Franklin Health District, infant mortality and teen pregnancy are considered high-priority issues.

For almost every health problem or health risk identified, reports address the impact on children. For example, when considering environmental health issues, children have increased risk of exposure to environmental contaminants. Because of their size and developmental factors they also have increased risk of experience adverse health effects as a result of exposure. While there are concerns about obesity, activity and nutrition in the general population, several reports specifically discussed the impact on children.

Section 3: Key Informant Interviews

The Board staff undertook three related efforts to gather qualitative information that could inform the Board's discussion about priorities. The primary goal was to solicit input about the kinds of issues that public health experts, opinion leaders, policy makers, advocates, and involved members of the public would like to see the Board focus on during 2001-03. The survey research was meant to expand the array of information available to the Board. The results are not quantitative or scientific, nor are they intended to be prescriptive.

Methodology

State Board of Health staff assembled a list of key informants with expertise in public health policy and implementation from around the state. They included legislators, legislative staff, members of congress and their staff, agency directors, gubernatorial policy staff, directors of minority affairs commissions, deans at public health and professional medical training schools, policy directors for professional and industry associations, officers from local health jurisdictions, and directors of health advocacy organizations. The preliminary list contained approximately 60 names.

Staff also developed a script for the key informant interviews that asked respondents about what they would recommend as priorities for the Board in 2001-03. It asked respondents to review the Board's criteria for choosing priority projects, to score the nine items on the Board's short list of possible priority projects, and to review and comment on the Board's list of six issues it has chosen to monitor. The script also asked about familiarity with the Board and it's work, influential sources of information about health policy, and three different models for organizing the Board's work. A copy of the interview script is attached as Appendix B.

Staff contracted with the Northwest Center for Public Health Practice to conduct interviews with key medical and public health faculty from around the state using the interview script. The center conducted 15 phone interviews. Many of the faculty NWCPHP interviewed had been on the staff's list of key informants.

Board staff members then divided up the 52 remaining key informants and conducted interviews with all informants who were available to participate. The staff completed 37 interviews (71 percent). Many of the people who were not interviewed were members of the Legislature or legislative committee staffers who were not available during the interview phase of this project because of the special session. The bulk of the interviewees are involved in one way or another in influencing public health policy at the state, local, national level. A list of people interviewed by Board staff and NWCPHP is attached as Appendix C.

Finally, Board staff created a Web-based survey form that mirrored the interview script and posted it prominently on the Board's Web site. When Board staff attended meetings they encourage people to participate. A notice also went to everyone who receives Board agenda materials electronically. A copy of the survey form is attached as Appendix D.

Twenty-three people completed and submitted the survey, although a few respondents focused on one issue and did not address most the questions. Twenty submissions were reasonably complete and responsive. Respondents were public health officials, public health researchers, professional school faculty, health and environmental advocates, medical practitioners, local public health employees. The population did not differ radically in professional composition from the population of people interviewed in person, although there appeared to be a slightly higher level of issue advocacy and activism.

Familiarity with the Board

Interviewers asked two questions related to familiarity with the Board. One question asked the subjects to describe how familiar they are with the Board's activities and which they thought were the most important. The other asked them to describe the Board's role.

A large number of respondents said they were not familiar with the Board's activities and could not name any projects or define its role (a third of people interviewed by staff).

Some people who said they were familiar with the Board could not name Board projects or describe the Board's role with any accuracy. Those people who were familiar with the Board, knew about current activities and could provide a reasonably accurate description of the Board's role were generally those people with whom the Board works on a regular basis.

Some subjects attribute broader powers to the Board than it has under statute:

> *"The Board of Health sets health policy for the state."*

> *"I guessed that it is an oversight body for the Department of Health."*

Several respondents said they had trouble distinguishing between the Board and the Department of Health (DOH). Others unknowingly confused the activities of the Board with those of DOH.

> *"[I] am getting an interesting perspective on the Board of Health getting involved in setting standards for [hospitals]. …The Board of Health has been doing site visits and has been involved in closing things."*

The ranks of people who claimed no familiarity with the Board include several key people who, given their duties, would be expected to have regular dealings with the Board. One agency head expressed surprise that the Board's duties overlapped with the agency's activities and a member of the Legislature who is very involved in health issues stated:

> *"I really don't know what their mission is."*

When asked to describe the role of the Board, several people mentioned the Board's rule-making authority. Terms and phrased used most were *rule making*, *setting policy*, and *regulation*.

Most of them, however, focused on the Board's ability to convene forums and gather input. Commonly used words and phrases included *unique*, *convener*, *providing a forum*, *catalyst*, *advocate/advocacy*, *public input*, *objective*, and *bully pulpit*.

> *"The Board should be a convener across disciplines to look at the larger picture. It has research capacity and the ability to scan every topic available to us. People in agencies don't have time to think. They have to deal with the day-to-day mundane stuff. The Board can hold forums to think about larger issues, to look at the total construct."*

Setting Board Priorities

The survey instruments asked people to name what they thought the Board should adopt as priorities during 2001-03. In most cases, this question was asked before participants saw the Board's short list of possible priorities, criteria, or list of issues to monitor. Subjects who had seen the interview script in advance—including all academics interviewed—tended to let the Board's short list influence their own choices.

People had lots of ideas. Commonly mentioned subjects were obesity, children's health, mental health parity, children's mental health, fluoridation, protection of vulnerable populations (particularly the elderly), end of life care, health disparities, various environmental health issues, workforce shortages, and data standards.

Access to affordable, quality health care

The most interesting feedback had to do with the Board's role in access, health-care financing, and the widely held perception that we are experiencing a serious breakdown of the health-care delivery and finance systems. People were divided about the Board's role in this crisis. A relatively large number of people said the Board should—many said must—get involved in what they see to be the single most important public health issue facing the state. Support for this position was spread across all subgroups. Some people argued that the Board is uniquely positioned to tackle the subject because of its perceived objectivity and credibility and the fact that it is slightly removed from both politics and day-to-day program responsibilities.

> *"I think there is a role for the Board in the issue of access to health care and all the issues that swirl around that—the cost of providing services, what services that should be provided, and maybe looking at the way Oregon chose to go."*

> *"Somebody should be doing a better job of looking out for health care for everyone—issues like the availability of insurance and under-reimbursement of health care providers. The whole system is having organizational and financial health problems of its own."*

> *"We're collectively acquiescing. Somebody needs to be in charge of convening—someone with throw weight to talk about things that need to be talked about."*

> *"Inflationary costs are out of control. We're cutting people out of health care. Drug costs are a two-edged sword—you have an industry with too much profit and yet people are enjoying better health status.*

When interviewers asked people to describe what they thought the Board's priorities should be, the key phrase mentioned most often was *access to care*. People mentioned this more than twice as often as the second most commonly used phrases, *health disparities* and *workforce shortages*. Related phrases that respondents also used multiple times included *health care costs, medical care financing, prescription drug prices, access to insurance, health care for the poor, health care reforms,* and *health care costs.*

In addition to mentioning workforce shortages several times, people also expressed related concerns by using phrases such as *capacity*, *rural health*, and *provider reimbursements*.

A smaller but still significant number of key informants, however, said the Board had no authority to address these issues, did not have the clout to take on the insurance system, did not have the staffing level to make a difference, or could not add much when so many people were already involved in the issue. One member of the Legislature said:

> *"I don't see how the Board could add anything."*

Very few people got down to specifics about what elements of these issue areas the Board might take on and what the final work product might look like. The most common project mentioned was to hold forums (possibly on TVW or public television) to discuss the gap between people's expectations and our ability to pay.

> *"You need to shorten the line or thin the soup. Someone needs to lead a public discussion around allocation of resources."*

Health Disparities

Respondents mentioned *health disparities* with the same frequency as workforce shortages.

Children's Health

The next most frequently occurring key word was children's health. Mentions of children's mental health were also common. One respondent raised the issue of the privacy of children's medical records.

Vulnerable Populations

Respondents mentioned protection of *vulnerable populations* several times, but not everyone had the same populations in mind. Several emphasized the elderly, and this was in addition to multiple mentions to the need to provide health care to seniors. There were multiple mentions of the need to protect frail elderly in adult family homes and institutional settings. Other people, however, emphasized children, the homeless, the developmentally disabled, and the poor.

Public Health Infrastructure

A group of answers were related to the ability of the public health infrastructure to deliver services and conduct assessments. The key phrase *public health infrastructure* showed up several times. There were also calls for more support for the Public Health Improvement plan, calls to look at the capacity of the public health workforce, and calls to provide standards for collecting and reporting public health data.

Environmental Health and Quality

Several respondents advocated the Board's involvement in a range of environmental issues. Some mentioned the broad categories of *environmental health* and *environmental quality*. Some named specific issues—*persistent bioaccumulative toxins* (PBTs), *global warming*, *nuclear cleanup*, *medical waste*, *air pollution*, *water pollution*, and *pesticides*. Respondents also raised concerned about the health impacts of the *drought*, the *transportation* crisis, and the *energy shortage*.

Other Issues

The list of items named at least once is lengthy. It includes:

- Tobacco cessation
- Addictions (drugs, alcohol)
- Bioterrorism
- Noise pollution
- Sociodeterminants of health
- Nosocomial strains
- Chronic conditions
- Immunizations
- Food safety
- On-site sewage
- Violence
- Gun control
- Suicide
- Access to mental health
- Cancer prevention and treatment
- Vaccinations
- Fetal alcohol syndrome
- Genetics
- Population growth
- Oral health
- Cell phone radiation
- Gambling

Specific Projects

Respondents were rarely specific about ways the Board could or should contribute to efforts to address any of these broad issues. Even when asked, they rarely explained how to focus the work or what a work plan or work product might look like. There were, however, some exceptions, including:

- As mentioned above, host roundtable discussion groups—perhaps at public meetings or using the talk show format on TVW or public television—to explore the issues behind the current health care crisis (the uninsured and underinsured, financing, access, workforce shortages, etc.)
- Assume the state will eventually move to a defined benefits program, something like the Oregon list, and prepare a strategy for managing the transition in a way that minimizes disruption, chaos, and anxiety.
- Study and propose "out-of-the-box" ways of approaching obesity and physical activity. For example, prepare a toolbox for local communities to use to encourage more activity. Another option would be to promote pedestrian-friendly development models as beneficial to health.
- Begin a public discussion or prepare a white paper about how government can reduce obesity and encourage nutrition and activity in an anti-authoritarian, anti-government culture. Alcohol has long been regulated and people are getting used to more invasive tobacco-cessation efforts—what about diet.
- Prepare a report that examines the health impacts of environmental issues and proposes a statewide environmental strategy. The report would help bring the combined weight of state government to bear on environmental issues and ease the concern that issues are being framed as only environmental when there are real health consequences.
- Prepare a guide to who does what among different state health agencies.
- Take a comprehensive look at scope of practice and propose solutions that would increase access by making better use of existing professionals,
- Examine and report on what happens to people's access to care as they come off welfare.
- Develop the idea of cumulative impacts in the context of toxics—small amounts may be unregulated but the cumulative impact may be harmful.
- Develop measurable performance measures for state agencies to gauge how well they are protecting the health of workers, the public, and the environment.
- Look at the impacts on children's development from exposure to environmental toxins—children tend to be more sensitive.
- Become actively involved in the state's Fetal Alcohol Syndrome Agency Task Force. Also, encourage alcohol treatment programs for pregnant women.
- Continue to work on specific components of the Public Health Improvement Plan.
- Grapple with the issue of advertising and how that influences consumption of non-nutritious, high-caloric-density foods (e.g., soda pop).
- Survey and assess the number and quality of pharmacy assistance programs.
- Expand children's preventive services list to include mental health.
- Explain reasons people disagree about science concerning cell phone safety.

Board Criteria

Respondents were asked to review and comment on the Board's criteria for evaluating possible priority projects. Interviewers presented the following list of nine criteria:

1. Does the issue involve multiple agencies?
2. Will there be measurable outcomes as a result of the work?
3. What is the prevalence and severity of the health threat and are interventions available?
4. What is the level of awareness and readiness on the part of the public, politicians, and professionals to deal with the issue?
5. Is the work statewide in scope?
6. Does the board have statutory authority to deal with this issue?
7. Are there sufficient resources to tackle the issue?
8. Does the board have a potentially unique role in dealing with this issue or would it be more appropriate for another agency to take the lead?

Nearly everyone interviewed agreed on first read that the list of Board criteria was a good list. Most respondents stopped there. Many went on however to suggest slight changes to the existing criteria, to challenge one or more of the existing criteria, or to suggest an additional criterion.

One person suggested changing the criterion about the seriousness of the health threat to also include the importance of the health benefit. Another suggested it should include the perception of risk. Another suggested this criterion include something about emergence. A few people expressed concerns that the needs of special populations and vulnerable populations be considered even if their smaller numbers make the threat to the overall population seem smaller.

A few people questioned whether the work needed to involve multiple agencies. One policy analyst asked, "Who cares?" Similarly, some people questioned why the work should involve multiple agencies? One person asked, "Isn't one enough?"

Some questioned whether the Board needed to be concerned about specific statutory authority given its broad mandates to recommend public health policy and to "explore ways to improve the health status of the citizenry." Several people asked whether the Board should forgo tackling important issues because it lacked resources or there was no awareness or readiness.

> *"If there aren't resources, go get them. This shouldn't limit your focus."*
>
> *"If there doesn't appear to be a lot of readiness, I'm not sure it isn't appropriate for the Board to go out and create that readiness if it's deemed to be an important enough issue."*

A number of people encouraged the Board to expand the list to more specifically include a gap analysis, efficiency analysis, or cost/benefit analysis.

> *"The only thing that's missing is the question: Is anyone else doing the work?"*
>
> *"We also need to look at dollar amount—return on investment, cost-efficiency, cost/benefit."*
>
> *"Are we spending the money productively or is there a way to do it more effectively?"*

Other suggestions for new criteria included:

> *"Does the policy item or research item conflict with any public policy in place? Is there a perception of policy conflict?"*
>
> *"Does the way we work with the health issue promote greater citizen ownership and responsibility?"*
>
> *"Is the Board uniquely situated to deal with it? Are there characteristics of the Board that allow it to deal with it in a way other entities might not be able to?"*
>
> *"Is there a clear definition of the problem? We tend to jump right to solutions when we should spend 90 percent of our time doing a good, objective job of defining the scope and nature of the problem."*
>
> *"Can the Board be a fulcrum or leverage point? Is there a strategic opportunity?"*
>
> *"The one I don't see here is: What is the magnitude of the problem? And how does it relate to other public health problems?"*
>
> *"What is missing from the list are criteria reflecting the fact that we are moving from a state-governed health care system to a market-driven system, and in such a system resources are allocated differently."*
>
> *"Will this work have a long-term, sustainable positive effect?"*

It was clear that many respondents were thinking of the criteria as a list of characteristics that had to be met by every priority project—deal breakers and deal makers—rather than as a matrix for subjectively weighing various factors. Some respondents suggested that the criteria should be weighted, with emphasis placed on the severity of the health threat.

Ranking the Board's Short List

The interview script and the Web survey provided a "short list" of nine possible priority projects the Board might consider:

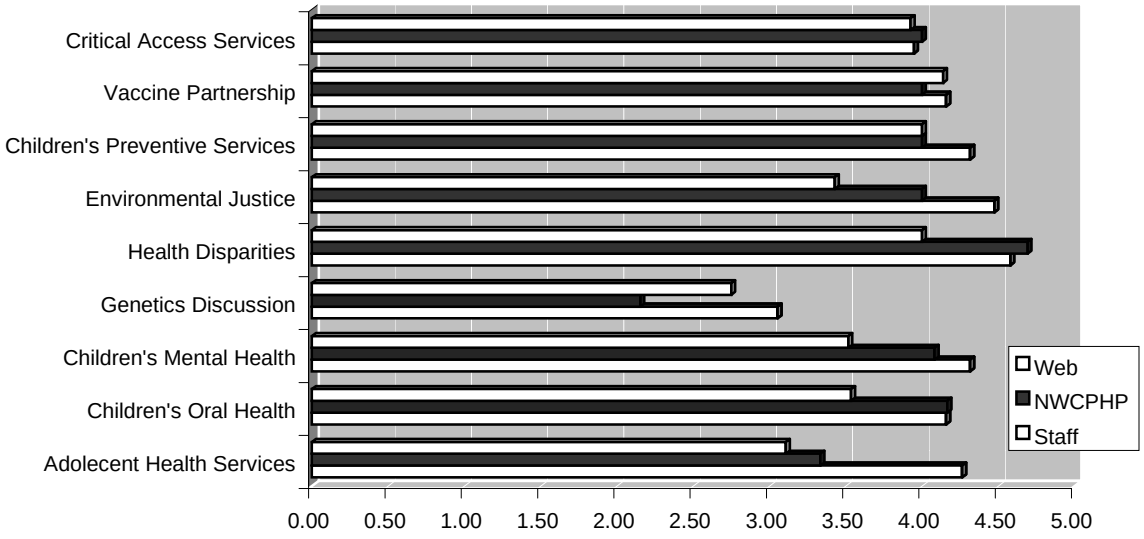
1. Continue work on the Board-approved "menu" of critical health services by seeking consensus among providers, community members, public health and other agencies, and by working with state and local agencies to assess current access.
2. Convene a public/private partnership to develop financing plan for continued universal distribution of childhood vaccines.
3. Continue work on list of Board-approved list of clinical preventive services for children (birth to age 10) by exploring delivery models and expanding the focus to include prenatal and perinatal care.
4. Continue implementation of environmental justice work—for example, work with local public health jurisdictions on meaningful community input.
5. Expand the Board's work on health disparities to include contributing factors other than workforce diversity—such as poverty, environmental and occupation conditions, nutrition, genetics, and behavioral choices.
6. Foster and improve the public dialogue about advances in genetics, particularly as they relate to racial, ethnic, or other special populations most directly affected by genetic-based tests, treatments, and technologies.
7. Study and make recommendations on children's access to mental health care.
8. Study and make recommendations on children's access to oral health care.
9. Study and make recommendations on health issues for adolescents.

Interviewees were asked to rate items on the Board's short list on a scale of 1 to 5, where 5 represented a strong belief that the item should be a Board priority and 1 indicated that it should absolutely not be a priority.

Overall, health disparities drew the most positives and had the highest average score. It was first in support among academicians and people who responded to the Web survey. It was a close second among people interviewed by Board staff. Genetics was "the weakest link," followed by adolescent health. Academic informants tended to give high scores and the averages for most items ran in the 4.0 to 4.1 range. Web respondents tended to be more generous toward most issues, and in particular toward environmental justice and adolescent health. The informants interviewed by staff differentiated more. After health disparities, the highest scores went to children's preventive services and vaccines. See Chart 1 for more information on the average scores.

Respondents were also invited to share their thoughts on why they scored various items the way they did. Some scores were simply based on personal interest or the core interests of a group or constituency the subject had chosen to represent. In many instances, however, respondents were able to give a clear and specific rationale. Some gave low scores because of lack of interest or a sense the issue is not important, but for others, a low score indicated a belief that the work would prove unproductive, that it was already being done, or that another entity could do it better.

Chart 1: Average Score for Items on Board's Short List



Critical health services: Some people noted, as one respondent put it, "When you are talking about 'access,' you need to know what you are talking about." Many people supported this because they saw it as a way to get closer to something akin to the Oregon list. A few scored it low for the same reason. One interviewee said the Board was not likely to get consensus on the list and saw it as a low yield/high effort undertaking.

> *"Someone needs to define basic health services. We have not yet pushed enough on that."*

> *"We need to work on the issue of access but I don't see this as a productive step."*

Vaccine partnership: People had a tendency to want to take care of children and gave relatively high scores to items regarding children's health. A few people who ranked this low seemed to think the issues had been dealt with. Others felt we are facing a crisis.

> *"We are in critical danger of losing universal vaccination and universal distribution because of the cost."*

> *"The work has already been done.*

Children's preventive services: A few people scored this high but said they would work on access for ages 0 to 10, not expand the scope. One person said the Board should examine the fact that providing preventive services to children reduces physician income in most practice settings.

Environmental justice: Many people interviewed by Board staff didn't seem to know much about the issue. Several asked the interviewers for explanations. A few saw environmental justice as a subset of the health disparities work.

> *"Is environmental justice a health care issue? It seems to be diverting the Board. It's a board of health, not a board of justice and privacy, although I guess justice and privacy are related to health."*

> *"Environmental justice is very important in terms of long-term health and the health of state. Crosscut this with asthma and the growing incidence in this state."*

Health disparities: For a large number of respondents, the need to work on health disparities was a given and didn't require much comment.

> *"I don't know where else at the state level these priorities are going to be discussed. Where will it happen if not from the Board of Health?"*

Genetics: Some people admitted they just weren't knowledgeable about genetics or the issue made them uncomfortable. Some people said the issue is being addressed by other entities with more expertise. Others said the issues are a few years out and the timing is not critical.

Children's mental health: Some of the people who rated this high said that they would prefer the work on mental health not be limited to children's issues.

> *"Children's mental health and adolescent health issues have been neglected. At DSHS, the older you are, the lower priority you are."*

Oral health care: Some interviewees said this is already being done well by programs such as Watch Your Mouth. Another identified it as—in the words of one respondent—"a huge hole."

Adolescent health: Some people said there has already been a lot of attention paid to adolescent issues. One person said that proceeding on this issue requires political commitment not more studies.

> *"I'm tired of all the work related to adolescents."*

> *"I don't think it would rise to that level of importance."*

Issues to Monitor

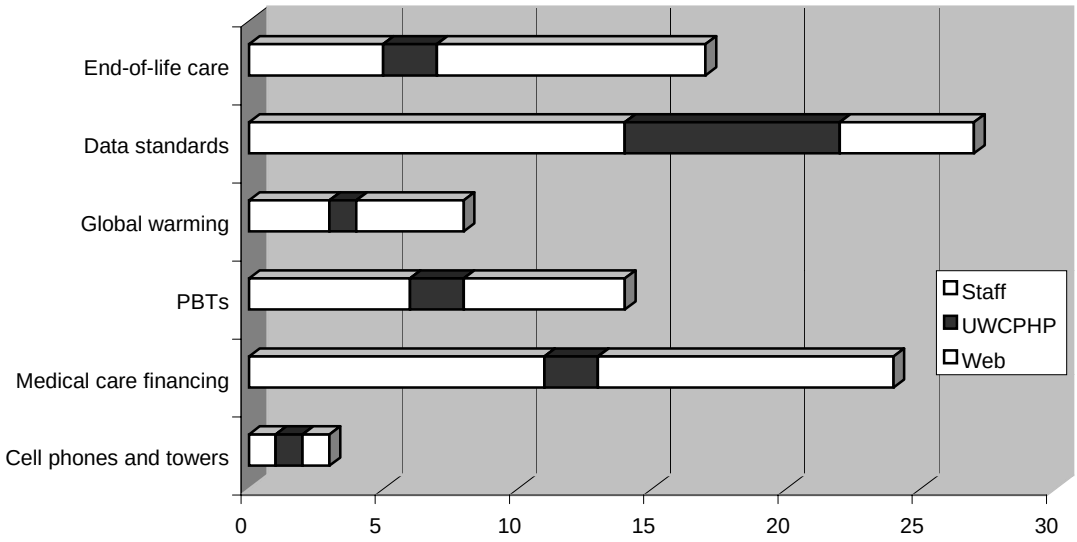
Interviewees were read the list of six issues the Board has chosen to monitor:

1. end-of-life care
2. data standards
3. global warming
4. persistent bioaccumulative toxins
5. medical care financing
6. cellular phones and telecommunication facilities.

The items on the lists were not defined unless the subjects of the interviews asked for clarification. When people answered, they may have had different ideas about what they meant. Data standards, in particular, seemed to mean different things to different people, so it would not be safe to assume that everyone who said promote data standards to a priority had the same work in mind. Similarly, people's answers suggested they had different things in mind when they spoke about end-of-life care.

Interviewees were asked to identify any issue that should be elevated to priority status. There was significant support for elevating data standards and medical care financing. There was relatively little support for elevating global warming and cell phones. (See Chart 2).

Chart 2: No. of Respondents Who Would Promote from Monitor to Priority



Most of the people interviewed by Board staff members were also invited to indicate whether any issues now being monitored should be removed from the list. A strong modal response emerged. A significant majority of respondents wanted to elevate health care financing and data standard from monitor to priority work status. Comparable majorities favored continuing to monitor end-of-life care and PBTs, while dropping global warming and cell phones and telecommunications towers.

Subjects interviewed by NWCPHP were not invited to recommend dropping certain issues, but several of them offered opinions when they thought an issue was not worth monitoring. The pattern observed with this group of academics was similar to, although less striking than, the pattern observed in the group interviewed by Board staff. As a group they were inclined to raise data standards to priority status and disinclined to add PBTs, global warming, or cell phones.

It's interesting to note that some academic respondents suggested—as they did when reviewing the short list of priorities—that some are still in the realm of scientific research and therefore outside the Board's purview. One stated the data standards and health-care financing are global, not state, issues and are too big and complex for the Board to tackle.

> *"Overall, the Board should be involved in policy and advocacy; they are not a scientific body."*

People who submitted the Web survey form strongly favored elevating the status of medical care financing. The runner-up for elevation was end-of-life care. As a group, respondents were not inclined to elevate cell phones and telecommunications facilities. There was, however, more support for global warming.

Interviewees were also asked to explain the reasons for their choices.

End-of life care: Most people who favored promoting this noted the aging of the population. One person said the Board's involvement would only duplicate the work of the end of life coalition put together by the AARP. A few people suggested this issue is too closely related to the delivery of medical care and that the Board should focus only *public* health.

> *"This is one of the things that hospice is doing a superb job with. We know this works and that there are good providers doing this that need to be encouraged and left alone."*

> *"Is the Board the right entity to be doing this? No one seems to be teeing up on this issue."*

Data standards: There was widespread agreement that this was important, but several people felt it was being addressed through HIPPA or DOH's work in connection with the Public Health Improvement Plan.

> *"The data needs are critical, especially standards for morbidity data."*

"No. BOH has no experience or expertise in this area, covered by DOH."

Global warming: People felt we needed more information or that the information we did have didn't clearly indicate a threat to public health.

PBTs: Several people said we needed more information about the effects on human health and the way these toxins interact in the environment. Some people noted the split between parties in the Legislature on whether to continue funding PBT work.

"There's not enough political consensus."

Medical care financing: People consistently argued for the importance of this issue, and many pleaded for the Board to take a role. But not everyone believed that the Board needed to be involved.

"If you have extra time. I have to imagine there are a lot of other people, including industry, already looking at this."

"It's not clear the Board can make a difference in health care financing."

"Unless they are prepared to take on the entire insurance industry, then good luck."

"Medical costs are spiraling out of control and people need help, not only with paying the bills but in accessing services."

Cell phones: The bulk of the respondents scoffed that this was on the list. Others said not enough is known about potential health risks.

"WHAT?!?!"

"The Board of Health is not a scientific group, so if the focus is on radiation impacts, this wouldn't be appropriate. If the issue has to do with danger of use in cars, this would be appropriate."

One health advocated submitted more than 100 pages of documents to support his belief that this issue should be a priority project. He advocated for working on both the vehicle safety issue and the radiation hazard issue. Much of the material challenged the objectivity of the Harvard Center for Risk Analysis, its director John Graham, and its July 2000 report that concluded it would be premature to restrict cell phone use by drivers.

Alternative Board Processes

The script and the Web survey form described three models for organizing the Board's work—the current model of focusing on a small number of priorities; a model that puts more resources into the state health report; and the rapid response model that would anticipate and react to emerging issues over a shorter timeframe. Respondents were specifically asked to respond to the last two alternatives. The most common pattern of responses, the mode, went something like this—continue to do priority projects and perhaps do some rapid response projects as long it they didn't deplete the Board's capacity to complete its priorities. This pattern was most strongly evident among people interviewed by Board staff. The academics were significantly more likely to favor a comprehensive report. There was no clear pattern in the responses from the on-line survey.

Priority Projects

There was consistent support for the priority setting process the Board has been employing. Two-thirds of the respondents either applauded that process or discouraged significant reliance on either of the alternative processes. More than half the people interviewed by Board staff praised the current process. These responses are noteworthy because neither the interview script nor the survey form specifically asked people to comment on it.

State Health Report

Support for doing the report varied between groups. People close to government, including agency heads, overwhelmingly discounted the practical value of the report. Slightly less than two-thirds of those interviewed by SBOH staff discouraged the Board from putting resources into it. The few supporters in the policy loop for local and state government included a member of the Legislature and two committee staffers. The dominant reason for opposing the report was that it would be ignored. Some people said it would be redundant with other reports, or that the report should be done by another agency.

Roughly half the academic respondents favored the general idea of a report, although many qualified their comments—saying, for example, that they had doubts that the Board had the resources to do it well, that a two-year planning horizon was too short (one respondent favored a report every decade), that the report may be redundant with PHIP, or that perhaps the Board was not the right agency to do it.

> *"I am trying to think about when the state health report has ever been useful. So many other things are going on in the way of report writing. The Board should be a partner in those other efforts."*

> *"The state health report is not a good use of staff time."*

"The report is really important. They should be doing that."

Rapid Response

About a third of the respondents in the interviews conducted by staff also expressed interest in the rapid response model but nearly all support was qualified. The remainder, for the most part, opposed any kind of rapid response. There were only a few exceptions. The dominant message among people interested in this model was to do it only if it did not interfere with the priority projects.

Roughly two-thirds of the academics spoke against the rapid response model. Only a few people suggested that the rapid response model become the primary mode for organizing the Board's work. A few said this is the role of the Health Policy Analysis Program at the University of Washington.

The positives for the rapid response were that it would make the Board's work more timely and relevant and raise its profile. The negatives were that it would detract from deeper work, make the Board too proactive, and make it appear as if the Board is simply chasing headlines.

"This is probably not realistic given limited staff and resources."

"You'd be in the game a lot more. You'd be setting yourselves up in a position to influence state agency behavior more."

"Leave the media work for the legislators."

"The only product would be a policy brief and you wouldn't really accomplish anything."

"This might be helpful if time permits."

"I'm excited by the idea, but wouldn't want it to supplant the priority work. It shouldn't be the only tool but there may be instances where the Board could precipitate a conversation."

Other suggestions

Two individuals independently suggested putting more resources into traditional areas of Board responsibility—name rule making and sunrise reviews.

Appendix A: Survey of Surveys Source Documents

Local health assessments

- Communities Count 2000: Social and Health Indicators Across King County
- Snohomish County Behavioral Risk Factor Surveillance Report, December 1999
- Community Health Status Report, Benton County, July 2000
- Washington Health Foundation county-by-county assessments on Web site at www.whf.org.
- King County Health Action Plan, January 2000
- Health assessments are no longer required but a few jurisdictions continue to do them. DOH has agreed to make available copies of all of them

Statewide surveys from DOH

- The Health of Washington State: A statewide assessment of health status, health risks, and health systems, September 1996
- Annual Communicable Disease Report 1999
- Washington State Vital Statistics 1998
- Washington State Pregnancy & Induced Abortions Statistics 1998
- BRFSS (Behavioral Risk Factor Surveillance System). Federal data and data standard across states is available on the Web at www.cdc.gov/nccdphp/brfss. DOH has a much more extensive data set.
- MCH Division Five-Year Needs Assessment (unpublished draft)
- Top Ten Leading Cause of Death to Residents Sorted by 1999 Rank Order, 1990-1999
- For specific epidemiology questions, DOH can provide access to VISTA/PH database.
- American Indian Health Care Delivery Plan, July 1997
- Washington State Cancer Registry, available on the Web, http://198.187.0.44/WSCR/

Statewide Surveys from Other Agencies

- 2001 Tobacco, Alcohol & Other Drug Abuse Trends in Washington State, DSHS
- State of Washington's Environmental Health 2000, Department of Ecology

Public Health Improvement Plan Documents

- 2000 Public Health Improvement Plan
- Proposed Standards for Public Health in Washington State, DOH, September 1999

Federal Assessments

- Washington 2000 State Health Profile, CDC, DHHS
- America's Children and the Environment: A First View of Available Measures, EPA, December 2000
- Healthy People 2010: Understanding and Improving Health, U.S. DHHS, January 2000
- Washington: Burden of Chronic Disease, 1996, Burden of Chronic Disease by State, Centers for Disease Control
- Public Health Assessments for Washington, Agency for Toxic Substances and Disease Registration, CDC, are on the Web at http://www.atsdr.cdc.gov/HAC/PHA/

NGO/Academic Reports

- The State of Washington's Children, UW School of Public Health and Community Medicine for Kid's Count, Spring 2000
- Transition Report to the New Administration: Strengthening our Public Health Defense Against Environmental Threats, Pew Environmental Health Commission, January 2001
- A World of Difference, Sexual and Reproductive Health Risks, The PAI Report Card 2001, Population Action International
- The Right Start, Child Trends and Kids Count, Washington Profiles and State-by-State Rankings (teen birth, low birthweight, preterm, no prenatal care, unmarried births, etc.)
- Kids Get Care Background Paper, HPAP, December 1999
- Health-Care Policy Board Health Indicators
- Community Report, Seattle, Wash, Center for Studying Health Systems Change, Winter 2001

Public Opinion Research

- Public Opinion Research on Public Health, Environmental Health and the Country's Health Problems, Pew Charitable Trusts, May 1999
- National Survey of Public Perceptions of Environmental Health Risks, Washington State Component, Princeton Survey Research Associates for Health Track, August 2000
- The Kaiser Family Foundation Web-based archive of public opinion survey data on health issues
- Harris Poll #60, Public Health, overview by Humphrey Taylor, October 20, 1999
- Public Opinion Surveys on Health Care: A Reference List, Employee Benefit Research Institute, October 1999 (mostly on health care delivery and mostly dated).
- Health Priorities in Washington State: Results from a Telephone Survey of Washington State Residents, Summer 1997
- Survey on Public Health in Snohomish County, Snohomish Health District, March 1998
- American's Views on Health Policy: A Fifty-Year Historical Perspective, Health Affairs, March-April 2000

Popular Press Articles Indicating Media and Public Awareness

- Today's Press, printouts of daily reports from DOH clipping service
- CDC, Diabetes, obesity becoming epidemic, The Olympian, January 26, 2001
- Assorted articles about efforts to limit sale of sodas in the schools
- Coverage about school violence

Appendix B: Script for Interviews on Board Priorities

Name of person interviewed:

Title: Organization:

Interviewed by: Craig McLaughlin Date:

Familiarity with Board Activities

Which of the Board's activities in the past year or two are you familiar with—and which of those do you think were most important?

Role of the Board

Can you describe what you consider to be the Board's role?

Suggested Priorities

The Board is concluding its priority projects for the 2000-01 biennium, and is now working on setting priorities for 2001-03. What do you think are the three to five most important issues for the Washington State Board of Health to focus on in the next year or two—and why?

Are there specific areas of work within those issues that you believe are not getting enough attention?

Information Sources

I'm going to read a list of common sources of information about health.

- Scientific research journals
- Professional society publications
- Trade and specialty magazines
- Professional conferences
- Government reports
- Privately funded studies
- Electronic newsletters
- Electronic discussions Lists
- Web sites
- The popular press

What information sources help shape your own opinions about public health priorities? Whenever possible, be specific—for example, name a newsletter you read regularly or a foundation whose reports you find to be particularly informative and reliable.

Criteria

I'm now going to hand you a list of eight criteria for evaluating possible priority projects. Please take a few minutes to look over the list.

- Does the issue involve multiple agencies?
- Will there be measurable outcomes as a result of the work?
- What is the prevalence and severity of the health threat and are interventions available?
- What is the level of awareness and readiness on the part of the public, politicians, and professionals to deal with the issue?
- Is the work statewide in scope?
- Does the board have statutory authority to deal with this issue?
- Are there sufficient resources to tackle the issue?
- Does the board have a potentially unique role in dealing with this issue or would it be more appropriate for another agency to take the lead?

Are these the right criteria for the board to be using and are there other criteria would you suggest?

Can you explain how the priorities you recommended do and don't fit these criteria?

Board's Short List

Here is a list of nine possible priorities the Board is considering for 2001-03. Please take a couple minutes to read over the list.

I'm now going to read each of the items on the list. Please indicate on a scale of 1 to 5 whether you think the Board should take these on as priority projects.

5 = Definitely; 4 = Possibly; 3 = Not Sure; 2 = Probably Not; 1 = Definitely Not

___ Continue work on the Board-approved "menu" of critical health services by seeking consensus among providers, community members, public health and other agencies, and by working with state and local agencies to assess current access.

___ Convene a public/private partnership to develop financing plan for continued universal distribution of childhood vaccines.

___ Continue work on list of Board-approved list of clinical preventive services for children (birth to age 10) by exploring delivery models and expanding the focus to include prenatal and perinatal care.

___ Continue implementation of environmental justice work—for example, work with local public health jurisdictions on meaningful community input.

___ Expand the Board's work on health disparities to include contributing factors other than workforce diversity—such as poverty, environmental and occupation conditions, nutrition, genetics, and behavioral choices.

___ Foster and improve the public dialogue about advances in genetics, particularly as they relate to racial, ethnic, or other special populations most directly affected by genetic-based tests, treatments, and technologies.

___ Study and make recommendations on children's access to mental health care.

___ Study and make recommendations on children's access to oral health care.

___ Study and make recommendations on health issues for adolescents

Can you explain some of the reasons you rated the importance of these issues the way you did?

Issues to Monitor

In addition to the list of possible priorities, the Board is considering whether to monitor the following six issues:

7. end-of-life care
8. data standards
9. global warming
10. persistent bioaccumulative toxins
11. medical care financing
12. cellular phones and telecom

Do you think any of these issues should be considered priorities? If so, which ones and why?

Revisiting Recommendations

Having seen the Board's lists of criteria, possible priorities, and issues to monitor, would you change your list of recommended priorities? How and why?

Alternative Board Processes

The Board currently devotes most of its attention to a handful of priority projects. In other words, it takes a fairly limited, extremely focused approach. I'd like to get your response to a couple of other ways the Board could organize its work. Keep in mind that these different approaches aren't mutually exclusive, but the board has limited resources and can't do everything.

One option would be to focus the Board's resources on producing a state public health. According to statute, "Every two years, in coordination with the development of the state biennial budget, the state board shall prepare the state public health report that outlines the health priorities of the ensuing biennium." The Board must gather input at public forums, work collaboratively with local health jurisdictions and state health agencies, and collect and review the best available information. Health agency heads would be required to use the report to shape their agencies' budgets and request legislation. Putting together a comprehensive report with full interagency participation that would sets state health priorities for the 2003-05 biennium would consume the bulk of the Board's resources, and in past years the board has sometimes asked to be exempted from this requirement. What would be the advantages and disadvantages of taking this sort of intensive and comprehensive approach to shaping health policy for the state?

A third model would be to monitor breaking developments in science, medicine and public attitudes. The Board could then direct staff to prepare policy briefs on timely issues, and it could use its meeting time to explore these issues, inviting citizens as well as experts from business, government, and academia to shed light on the subjects. What do you think of this sort of "rapid response" approach to organizing board activities?

Appendix C: Key Informants

Individuals interviewed by State Board of Health staff

1. Jonnel Anderson, Senior Policy Analyst, Senate Republican Caucus
2. Dennis Braddock, Secretary, WA Department of Social and Health Services
3. Lisa Brown, Chair, Senate Committee on Ways & Means
4. Tanya Busch-Weak , Environmental Health Director, Clallam County
5. Rep. Gary Chandler, Co-Chair, House Agriculture & Ecology Committee
6. Onofre Contreras, Executive Director, Commission on Hispanic Affairs
7. Mary Conway, Legislative Assistant, Office of Senator Patty Murray, U.S. Senate
8. Kimberly Craven, Executive Director, Governor's Office of Indian Affairs
9. Senator Alex Deccio, Ranking Minority, Senate Health and Long-Term Care
10. Len Eddinger, Dir. Of Health Policy, WA State Medical Association
11. Tom Fitzsimmons, Director, WA Department of Ecology
12. Martin Fleck, Executive Director, Physicians for Social Responsibility
13. Barb Flye, Executive Director, Citizens Action
14. Senator Karen Fraser, Chair, Senate Environment, Energy and Water Committee
15. Kathy Gerke, Intergovernmental Relations Manager, Association of Washington Cities
16. Bill Hagens, Deputy Director, WA Office of the Insurance Commissioner
17. Amy Hanson, Coordinator, House Appropriations Committee
18. Maxine Hayes, State Health Officer, WA Department of Health
19. Ward Hinds, President-elect, WA State Association of Local Public Health Officials, and Health Officer, Snohomish Regional Health Department
20. Kenneth Hirst, Research Analyst, House Agriculture & Ecology Committee
21. Randy Hodgins, Senior Coordinator, Senate Committee on Ways & Means
22. Glen Hudson, Vice President for Governmental Affairs, Association of Washington Business
23. Carol Jolly, Policy Director, Office of the Governor
24. Tom Kelly, Deputy Superintendent, WA Office of the Sup. Of Public Instruction
25. Vicki Kirkpatrick, Administrator, WA State Association of Local Public Health Officials, Washington Association of Counties
26. Dave Knutson, Senior Analyst, House Health Care Committee
27. Jim Matsuyama, Environmental Health Director, North East Tri-County Health Department
28. Senator Bob Morten, Ranking Minority, Senate Environment, Energy and Water
29. Laura Porter, Executive Director, Family Policy Council
30. Richard Rodger, Coordinator/Counsel, Senate Environment, Energy and Water Committee
31. Gloria Rodriguez, CEO, WA State Association of Community and Migrant Health Centers
32. Ree Sailors, Health Policy Advisor, Governor's Health Policy Office
33. Jonathan Seib, Coordinator/Counsel, Senate Health and Long-Term Care
34. Brenda Suiter, Director of Rural and Public Health Policy, WA State Hospital Association
35. Senator Pat Thibaudeau, Chair, Senate Health & Long-Term Care Committee
36. Sandy Owen, Director, Preventive Health Services, Benton-Franklin Health Department
37. Ida Zodrow, Interim Administrator, WA Health Care Authority

Individuals interviewed by Northwest Center for Public Health Practice staff

1. John Coombs, Associate Dean, University of Washington School of Medicine
2. Dorothy M. Detlor, Dean, Intercollegiate College of Nursing, Washington State University
3. William Dowling, Chair, Department of Health Services, University of Washington School of Public Health and Community Medicine
4. Barry Hicks, Associate Professor, Health Policy Administration, and Director, Center for the Advancement of Community Health, University of Washington
5. Eric Larson, Medical Director, University of Washington Medical Center
6. Robert Ozuna, Director, Rural Technology Center, University of Washington at Heritage College
7. Janet Primomo, Professor, Nursing Program, University of Washington–Tacoma
8. Elayne Puzan, School of Nursing, Seattle University
9. Roger Rosenblatt, Director, UW Physicians Group, Family Medicine
10. Charles Royer, National Program Director, Robert Wood Johnson Foundation Urban Initiative
11. Carolyn Schultz, Professor, School of Nursing, Pacific Lutheran University
12. Charles Treser, Senior Lecturer, School of Public Health and Community Medicine, University of Washington
13. Karen VanDusen, Director of Environmental Health and Safety, University of Washington
14. Patricia Wahl, Dean, School of Public Health and Community Medicine, University of Washington
15. Nancy Woods, Dean, School of Nursing, University of Washington

Appendix D: On-line Survey About Board Priorities

Washington State

Board of Health

Survey on Board of Health Priorities, 2001-03

The Washington State Board of Health is concluding many of its priorities projects for 2000-01, and it is now working to establish priorities for 2001-03. By completing the form below, you can inform that process.

A note about confidentiality: When you submit this form, your responses will by sent by e-mail to the State Board of Health. The Board intends to keep all responses confidential. The staff report on the findings of this survey may quote specific responses, but will not attribute those responses to individuals. Keep in mind, however, that under state public records law, all electronic messages to and from the Board of Health may be disclosed to the public.

Name:

1. Which of the following best describes your role in medicine, public health, or public policy?

--Select A Response--

2. How familiar are you with the Washington State Board of Health and its work?

--Select A Response--

3. What do you think are the three to five most important issues for the Washington State Board of Health to focus on in the next year or two—and why? Please mention if there are specific areas of work within these issue areas that are not getting enough attention.

1. 

2. 

3. 

4. 

5. 

4. What kinds of information sources do rely on most to help you form opinions about the relative importance of public health issues? (Check any that apply.)

- ☐ Scientific Research Journals
- ☐ Professional Society Publications
- ☐ Trade/Specialty Magazines
- ☐ Professional Conferences
- ☐ Discussions with Peers
- ☐ Television
- ☐ Newspapers
- ☐ Popular Magazines
- ☐ Radio
- ☐ Electronic Discussion Lists
- ☐ Electronic Newsletters
- ☐ Web Sites

If you use other kinds of sources, what are they?

Please name any specific journals, newsletters, agencies, or other sources you rely on most?

5. The board has established eight criteria for evaluating possible priority projects:

1. Does the issue involve multiple agencies?
2. Will there be measurable outcomes as a result of the work?
3. What is the prevalence and severity of the health threat and are interventions available?
4. What is the level of awareness and readiness on the part of the public, politicians, and professionals to deal with the issue?
5. Is the work statewide in scope?
6. Does the board have statutory authority to deal with this issue?
7. Are there sufficient resources to tackle the issue?
8. Does the board have a potentially unique role in dealing with this issue or would it be more appropriate for another agency to take the lead?

Are these the right criteria for the board to be using? What other criteria you suggest? And how do your recommended priorities fit these criteria?

6. The Board has identified a working list of nine possible priorities for 2001-03. Please indicate on a scale of 1 to 5 whether you think the Board should take the following items on as priority projects. (For more specific information on some of these projects, see the January 2000 Memo to Board Regarding Focusing Priorities for 2001-2002.)

Scale: 5 = Definitely | 4 = Possibly | 3 = Not Sure | 2 = Probably Not | 1 = Definitely Not

3 Continue work on the Board-approved **"menu" of critical health services** by seeking consensus among providers, community members, public health and other agencies, and by working with state and local agencies to assess current access.

3 Convene a **public/private partnership** to develop financing plan for continued universal distribution of childhood vaccines.

3 Continue work on list of Board-approved list of **clinical preventive services for children** (birth to age 10) by exploring delivery models and expanding the focus to include prenatal and perinatal care.

3 Continue implementation of **environmental justice** work—for example, work with local public health jurisdictions on meaningful community input.

3 Expand the Board's work on health disparities to include contributing factors other than workforce diversity—such as poverty, environmental and occupation conditions, nutrition, genetics, and behavioral choices.

3 Foster and improve the public **dialogue about advances in genetics**, particularly as they relate to racial, ethnic, or other special populations most directly affected by genetic-based tests, treatments, and technologies.

3 Study and make recommendations on **children's access to mental health** care.

3 Study and make recommendations on **children's access to oral health** care.

3 Study and make recommendations on **health issues for adolescents**.

7. In addition to the list of possible priorities, the Board is considering whether to monitor the following six issues:

1. end-of-life care
2. data standards
3. global warming
4. persistent bioaccumulative toxins
5. medical care financing
6. cellular phones and telecommunication facilities.

Do you think any of these issues should be considered priorities? If so, which ones and why?

8. Having seen the Board's lists of criteria, possible priorities, and issues to monitor, would you change your list of recommended priorities? How and why?

9. The Board currently devotes most of its attention to a handful of priority projects. It takes a fairly limited, extremely focused approach. We'd like to get your response to a couple of other ways the Board could organize its work. Keep in mind that these different approaches aren't mutually exclusive, but the board has limited resources and can't do everything.

One option would be to focus the Board's resources on producing a state public health. According to statute, "Every two years, in coordination with the development of the state biennial budget, the state board shall prepare the state public health report that outlines the health priorities of the ensuing biennium." The Board must gather input at public forums, work collaboratively with local health jurisdictions and state health agencies, and collect and review the best available information. Health agency heads would be required to use the report to shape their agencies' budgets and request legislation. Putting together a comprehensive report with full interagency participation that would set state health priorities for the 2003-05 biennium would consume the bulk of the Board's resources, and in past years the board has sometimes asked to be exempted from this requirement.

What would be the advantages and disadvantages of taking this intensive and comprehensive approach to shaping health policy?

A third model would be to monitor breaking developments in science, medicine and public attitudes. The Board could then direct staff to prepare policy briefs on timely issues, and it could use its meeting time to explore these issues, inviting citizens as well as experts from business, government, and academia to shed light on the subjects. What do you think of this sort of "rapid response" approach to organizing board activities?

What would be the advantages and disadvantages of taking this sort of "rapid response" approach to shaping health policy?

Thank you for taking the time to complete this survey. Please direct any questions or comments to Craig McLaughlin at Craig.McLaughlin@doh.wa.gov.

If you would like to receive a copy of the results of this survey, please provide an e-mail address:

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